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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **GREGORY EDWARD GRAY, M.D.** **1575 Spinnaker Drive, Suite 208** **Ventura, CA 93001** **Physician's and Surgeon's Certificate No. G52593,** Respondent.	Case No. 800-2017-036125 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about June 25, 1984, the Medical Board issued Physician's and Surgeon's Certificate No. G52593 to Gregory Edward Gray, M.D. (Respondent). Physician's and Surgeon's

Certificate No. G52593 was in full force and effect at all times relevant to the charges brought herein and will expire on September 30, 2019, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2227 of the Code states, in pertinent part:

"(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:

"(1) Have his or her license revoked upon order of the board.

"(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

"(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

"(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

"(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

"..."

5. Section 2234 of the Code, states, in pertinent part:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

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"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"..."

6. Unprofessional conduct under section 2234 of the Code is conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming to a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 575.)

7. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

FIRST CAUSE FOR DISCIPLINE
(Gross Negligence)

8. Respondent has subjected his Physician's and Surgeon's Certificate No. G52593 to disciplinary action under sections 2227 and 2234, as defined section 2234, subdivision (b), of the Code, in that he committed gross negligence in the care and treatment of Patient A,[1] as more particularly alleged hereinafter:

[1] The patient's identity is withheld to protect her privacy. Respondent knows Patient A's identity.

9. On or about February 28, 2011,[2] Respondent saw Patient A, a then thirty-six-year old woman, for an initial visit. Patient A reported a history of anxiety and depression since the age of fifteen, with numerous past medication trials of tricyclic antidepressants, selective serotonin reuptake inhibitor (SSRI) antidepressants, and Klonopin.[3] From her primary care physician, Patient A had been prescribed Prozac[4] and Xanax.[5] Respondent diagnosed Patient A with Panic Disorder and Major Depressive Disorder. He prescribed Prozac and increased Xanax from .25 mg, three times a day, to .50 mg, three times a day and as needed. Respondent failed to document Patient A's substance abuse history or any associated assessment at this initial visit.

10. Throughout the course of treatment, Respondent met with Patient A approximately every two (2) to three (3) weeks and adjusted her medications as her symptoms progressed. In the first six (6) months of treatment, Respondent prescribed Patient A Wellbutrin,[6] Ambien,[7] and Trazodone,[8] along with increasing doses of Xanax and Klonopin.

11. On or about August 22, 2011, Respondent was prescribing Patient A Prozac, Ambien, Trazodone, and Xanax, but had discontinued Klonopin as of an appointment on or about July 27, 2011. From February to August 2011, Respondent had quadrupled Patient A's Xanax dose, prescribing 3.50 mg daily.

12. Patient A's Controlled Substance Utilization Review and Evaluation System (CURES)[9] report shows that a Temazepam[10] prescription written by Respondent was filled on or about September 19, 2011. Respondent's medical records fail to document this prescription.

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[2] Conduct occurring more than seven (7) years from the filing date of the Accusation is for informational purposes only and is not alleged as a basis for disciplinary action.

[3] Klonopin, brand name for Clonazepam, is a benzodiazepine and a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d)(7).

[4] Prozac, brand name for Fluoxetine, is a SSRI antidepressant.

[5] Xanax, brand name for Alprazolam, is a benzodiazepine and a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d)(1).

[6] Wellbutrin, brand name for Bupropion, is an antidepressant.

[7] Ambien, brand name for Zolpidem Tartrate, is a sedative hypnotic and a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d)(32).

[8] Trazodone is a sedative and antidepressant.

[9] The Controlled Substance Utilization Review and Evaluation System (CURES) is a database of Schedule II, III, and IV controlled substance prescriptions dispensed in California serving the public health, regulatory oversight agencies, and law enforcement.

[10] Temazepam, brand name Restoril, is a benzodiazepine and is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d)(29).

13. On or about September 20, 2011, Patient A saw Respondent and reported that she had experienced complications after surgery for a deviated septum and had to go to the emergency room. She complained of considerable facial pain and poor sleep. Respondent advised Patient A to continue taking Prozac, Xanax, Ambien, and an increased dose of Trazodone. Respondent also prescribed Elavil[11] and increased Patient A's Xanax dose to 4 mg daily.

14. On or about October 10, 2011, Patient A returned to Respondent for a follow up. She complained of depression with anhedonia[12] and insomnia. Respondent added Buspar[13] to her medication regimen, and added Klonopin, 2 mg to be taken at bedtime. Respondent decreased Xanax to 1 mg daily as needed for anxiety.

15. On or about October 24, 2011, Patient A returned to Respondent for a follow up. She disregarded Respondent's prescribing instructions for Xanax and reported that she was taking 1 mg of Xanax three times a day in addition to the Klonopin. Respondent increased her Klonopin dose from 2 mg to 4 mg daily and increased Patient A's Xanax prescription to reflect her increase dose.

16. Patient A continued seeing Respondent regularly through the end of 2011. Throughout November and December of 2011, Respondent prescribed Patient A Effexor[14] (discontinuing Prozac), Elavil, Remeron,[15] Ambien, and Nortriptyline.[16] Respondent also increased Patient A's Xanax prescription to 4 mg daily as needed, and continued her on 4 mg of Klonopin at bedtime.

17. On or about February 16, 2012, Patient A saw Respondent and reported that she had increased her Xanax consumption to 5 mg daily. Respondent continued to prescribe her Xanax, Klonopin, Ambien, and Nortriptyline.

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[11] Elavil, brand name for Amitriptyline, is a nerve pain medication and a tricyclic antidepressant.
[12] Anhedonia is the inability to feel pleasure, and is a common symptom of depression.
[13] Buspar, brand name for Buspirone, is an anxiolytic used to treat anxiety.
[14] Effexor, brand name for Venlafaxine, is a nerve pain and antidepressant.
[15] Remeron, brand name for Mirtazapine, is an antidepressant.
[16] Nortriptyline, brand name Pamelor, is a nerve pain medication and tricyclic antidepressant.

18. On or about March 6, 2012, Patient A saw Respondent for a follow up and complained of back pain. Without doing a physical exam, Respondent prescribed Patient A Robaxin[17] for pain, and had her continue her other medications.

19. On or about March 22, 2012, Patient A saw Respondent for a follow up. She had been in an accident at a store and hurt her right shoulder and hip. Patient A told Respondent she had gone to the emergency room and gotten prescriptions for Norco[18] and Valium.[19] Patient A reported that the Valium was helping more than the Klonopin and Xanax. Respondent prescribed Patient A the following: (1) Lithium;[20] (2) Valium, 10 mg, one tablet to be taken four times a day; and (3) Norco, 10-325 mg, quantity 30, one tablet to be taken four times a day as needed. Respondent told Patient A to discontinue taking Xanax and Klonopin.

20. At the next visit, on or about April 2, 2012, Patient A told Respondent she had stopped taking Valium. Respondent had Patient A restart Klonopin at 4 mg taken at bedtime and increased her Xanax to 5 mg per day as needed.

21. From in or around April 2012 through June 2012, Respondent continued seeing Patient A and prescribed her Ultram[21] (which was quickly discontinued because of an allergic reaction), Topamax,[22] Lithium, Amitriptyline, Xanax, and Klonopin.

22. On or about June 25, 2012, Patient A saw Respondent and reported that she had increased anxiety and had been taking more than the directed amount of Xanax. Respondent documented that Patient A was reluctant to replace Xanax with Klonopin to begin a tapering procedure. Respondent decreased Patient A's Klonopin dose from 4 mg to 2 mg at bedtime and maintained her Xanax dose at 5 mg per day.

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[17] Robaxin, brand name for Methocarbamol, is a muscle relaxant

[18] Norco is the brand name for Hydrocodone Bitartrate and Acetaminophen. Hydrocodone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(I)(i).

[19] Valium, brand name for Diazepam, is a benzodiazepine and a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d)(9).

[20] Lithium is a medication used to treat major depressive disorder and bipolar disorder.

[21] Ultram, brand name for Tramadol, is a narcotic-like analgesic.

[22] Topamax, brand name for Topiramate, is a nerve pain medication and anticonvulsant.

23. On or about June 27 and June 28, 2012, Patient A called Respondent complaining of headache. Respondent initially prescribed Patient A Midrin,[23] then prescribed Fiorecet[24] and advised her to go to urgent care or an emergency room.

24. On or about July 9, 2012, Patient A saw Respondent and told him that her mother had accused her of drinking alcohol. Respondent documented that Patient A denied drinking alcohol, but noted that she had had slurred speech in a phone call with him. Respondent failed to document any information about Patient A's substance abuse history or a substance abuse assessment. Respondent increased Patient A's Klonopin prescription to 3 mg at bedtime and lowered her Xanax prescription to 3 mg a day. Respondent failed to document his rationale for increasing Patient A's overall benzodiazepine prescription.

25. At the next appointment, on or about July 24, 2012, Patient A reported to Respondent that she had increased her Xanax prescription to 4 mg daily. Respondent documented that he spoke to Patient A about the increased addiction liability of Xanax. He diagnosed her with benzodiazepine dependence. Respondent continued Patient A at 3 mg of Xanax daily and documented a plan to switch her to Klonopin by gradually tapering off the Xanax. Respondent documented Patient A's Klonopin prescription as 6 mg daily.

26. On or about August 9, 2012, Respondent lowered Patient A's Xanax dose to 2 mg a day and kept her Klonopin dose the same, at 6 mg daily.

27. On or about September 10, 2012, Respondent increased Patient A's Klonopin dose to 8 mg daily and had her discontinue Xanax.

28. On or about October 3, 2012, Patient A saw Respondent and complained of chronic headaches, anxiety, oversedation and fatigue. Respondent prescribed Patient A Elavil and Topamax. He also continued to prescribe Klonopin, 8 mg daily, and prescribed Xanax, 2 mg daily as needed for anxiety.

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[23] Midrin, a combination of Acetaminophen, Isometheptene, and Dichloralphenazone, is a medication used to treat migraines.

[24] Fiorecet, brand name for Acetaminophen-Butalbital-caffeine, is an analgesic commonly used to treat headaches.

29. From in or around October through December 2012, Patient A continued to see Respondent and continued taking her medications. On or about December 10, 2012, Patient A called Respondent and complained of nausea, vomiting, and light headedness. She also told Respondent she had been to the emergency room three times, and had a neurological appointment in two weeks' time. Respondent documented that he advised Patient A to see her primary care physician and to decrease her Elavil dose.

30. On or about December 11, 2012, Patient A met with Respondent for a scheduled appointment. Respondent gave Patient A prescription for Percocet,[25] 10-325 mg, quantity 80, two tablets to be taken twice a day as needed for severe headache. Respondent noted in the medical record that he was prescribing Patient A enough medication to last until her neurological appointment. Respondent also prescribed Seroquel for sleep, and refilled Patient A's Klonopin and Xanax prescriptions. Respondent did not document an assessment of the risks of combining both substances or any discussion with Patient A of these risks.

31. One week later, on or about December 18, 2012, Patient A saw Respondent and reported that her Percocet had been stolen. Respondent gave her another prescription for Percocet, 10-325 mg, quantity 80, and warned her that he would not refill the prescription again if lost or stolen.

32. On or about January 2, 2013, Patient A saw Respondent and complained of depression, pain, and headaches. Respondent recommended that Patient A see a pain management specialist. Respondent increased Patient A's Klonopin prescription to 4 mg taken at bedtime and 2 mg taken twice daily, and continued Patient A's Xanax prescription to 2 mg daily as needed for panic. He also started Patient A on Effexor.

33. On or about January 15, 2013, Patient A saw Respondent and complained of depression and pain. She reported that Effexor exacerbated her headaches. She told Respondent that she had an appointment with a pain specialist in February but needed a referral. Respondent documented that Patient A had lost ten pounds. He also noted that Patient A had facial and

[25] Percocet is the brand name for Oxycodone and Acetaminophen. Oxycodone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(M).

shoulder pain and chronic headaches. Respondent prescribed Patient A Cymbalta,[26] Elavil, Klonopin, and Percocet, and wrote a referral for the pain specialist. The Percocet prescription was for 80 tablets, one tablet to be taken four times a day, for pain or headache.

34. On or about January 31, 2013, Patient A saw Respondent and said that the pain specialist had canceled her appointment. She also reported that she had increased her Percocet dose to two tablets, four times a day because of her severe shoulder pain. Respondent noted that this was the second instance of Patient A increasing her medication dose without consulting with him. He referred Patient A to another pain management specialist and continued prescribing her Cymbalta, Elavil, Klonopin, and Xanax. He advised Patient A that her Percocet use was excessive and that she should not exceed three tablets per day. He gave Patient A prescription for Percocet, 90 tablets, one tablet to be taken every six to eight hours as needed for pain.

35. On or about February 26, 2013, Patient A saw Respondent and complained of anxiety, depression, and severe right shoulder and facial pain. She reported that she had run out of Klonopin and Xanax. Patient A's CURES report shows that she filled her Klonopin and Xanax prescriptions on or about January 31, 2013, again implying that she had taken more than the prescribed doses for these medications. Patient A said she was unable to make her appointment with the pain management specialist. Respondent refilled Patient A's prescriptions for Cymbalta and Elavil and gave her another referral to a different pain management specialist. He refilled Patient A's Klonopin and Xanax prescriptions and advised her that she should not increase the doses for these medications. The Klonopin prescription was for 2 mg twice daily and 4 mg at bedtime. The Xanax prescription was for 1 mg twice daily as needed for panic. Respondent also refilled Patient A's Percocet prescription, quantity 90, one tablet taken three times a day.

36. On or about March 19, 2013, Patient A saw Respondent and reported that her anxiety and depression had improved. She told Respondent she was unable to get an appointment with the pain management specialist he referred her to at her last visit. Respondent documented that he advised Patient A that she needed to see a pain management specialist and he would not continue to prescribe her Percocet indefinitely. Respondent referred Patient A to another pain

[26] Cymbalta, brand name for Duloxetine, is a nerve pain medication and antidepressant.

management specialist, and Patient A agreed to make an appointment. He discontinued Cymbalta and prescribed Effexor, Elavil, Klonopin, Xanax, and Percocet.

37. On or about March 29, 2013, Patient A called Respondent and said she lost her Klonopin medication. Respondent called in a prescription for Klonopin, 2 mg, quantity 30, and told Patient A that he would not replace any lost Klonopin again.

38. On or about April 12, 2013, Patient A saw Respondent and reported that she did not make an appointment with the last pain management specialist Respondent referred her to. She complained of severe right shoulder pain, depression, anxiety, and a tremor. Respondent reduced Patient A's Effexor dose, increased her Elavil dose, and added Propanolol[27] to treat her tremor. He prescribed Klonopin, 2 mg, quantity 90, and Xanax, 1 mg, quantity 60, and advised Patient A not to increase her Xanax dose. He also prescribed her 90 tablets of Percocet, one tablet to be taken three times a day, and emphasized that she had to go to a pain specialist.

39. On or about May 2, 2013, Patient A saw Respondent for the last time. She complained of anxiety at night, severe shoulder pain, and severe headaches. She once again reported that she had not made an appointment with a pain management specialist. Respondent reduced Patient A's Effexor dose, increased her Elavil, and prescribed Topamax for her migraines and advised her to see a neurologist. He also prescribed Patient A Klonopin, Xanax, and Percocet. Respondent documented that he told Patient A that he was concerned that she had become dependent on Percocet and that she still had not made an appointment with a pain management specialist. He also provided her with the name of a psychiatrist for an evaluation.

40. On or about May 16, 2013, Respondent documented that he had received a phone call from the Ventura County Medical Examiners office, notifying him that Patient A had died.

41. Respondent's medical records fail to accurately document when Respondent issued prescriptions to Patient A. When comparing Respondent's medical records to Patient A's CURES report within a 13-month time period between August 4, 2011, and September 9, 2012, Patient A filled approximately 24 Xanax prescriptions and 26 Klonopin prescriptions, each

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[27] Propanolol, brand name Inderal, is a beta-blocker used to treat high blood pressure and tremors.

allegedly a 30-day supply. Respondent's medical records fail to fully document all the prescriptions given to Patient A.

42. Respondent committed gross negligence in the care and treatment of Patient A for the following:

a. From in or around March through September 2012, Respondent failed to recognize a pattern of overuse of prescribed benzodiazepines and adjust the treatment plan accordingly;

b. On or about July 9, 2012, Respondent failed to assess the potential for oversedation from benzodiazepines after he observed Patient A slurring her speech, failed to re-assess Patient A's alcohol use beyond accepting her denial, and prescribed an increase in benzodiazepine dosing after a finding of slurred speech and possible alcohol use;

c. On or about October 3, 2012, Respondent prescribed Xanax to Patient A, whom he had previously diagnosed benzodiazepine dependence and was attempting to taper down her use of benzodiazepines. He prescribed Xanax despite the fact that Patient A had previously complained of oversedation on Klonopin and without any documentation demonstrating that Patient A was experiencing benzodiazepine withdrawal syndrome;

d. Respondent failed to recognize or document that he was issuing approximately twice as many benzodiazepine prescriptions as were called for in his treatment plan;

e. From on or about December 11, 2012 through May 2, 2013, Respondent continued to prescribe Percocet to Patient A, a patient with a history of benzodiazepine dependence who was taking high doses of benzodiazepines, without documenting a discussion of the risks of combining opioids with benzodiazepines, including oversedation, respiratory depression, and death;

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f. On or about December 18, 2012, Respondent failed to recognize patterns of unreliable and/or aberrant use of prescription medications and adequately assess the patient before deciding to re-issue another Percocet prescription; and

g. Throughout his treatment and care of Patient A, Respondent failed to adequately and accurately document the issuance of controlled substance prescriptions for Klonopin and Xanax.

SECOND CAUSE FOR DISCIPLINE
(Repeated Negligent Acts)

43. Respondent has further subjected his Physician's and Surgeon's Certificate No. G52593 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in the care and treatment of Patient A, as more particularly alleged hereinafter:

44. Paragraphs 9 through 42, above, are hereby incorporated by reference and re-alleged as if fully set forth herein.

45. Respondent committed repeated negligent acts in the care and treatment of Patient A for the following:

a. On or about April 23, 2012, Respondent failed to perform and document an adequate assessment of Patient A's headache complaints prior to prescribing Topamax;

b. On or about June 27, 2012 and June 28, 2012, Respondent continued to treat Patient A's headache complaints with prescription medications without completing an adequate assessment of her complaint; and

c. From December 11, 2012 through on or about May 2, 2013, Respondent failed to perform and document an adequate assessment of Patient A's pain prior to prescribing Percocet.

THIRD CAUSE FOR DISCIPLINE
(Failure to Maintain Adequate and Accurate Records)

46. Respondent has further subjected his Physician's and Surgeon's Certificate No. G52593 to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the

Code, in that he failed to maintain adequate and accurate records for Patient A, as more particularly alleged in paragraphs 9 through 45, above, which are hereby incorporated by reference and re-alleged as if fully set forth herein.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate No. G52593, issued to Respondent Gregory Edward Gray, M.D.;

2. Revoking, suspending or denying approval of Respondent Gregory Edward Gray, M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code, and advanced practice nurses;

3. Ordering Respondent Gregory Edward Gray, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: March 28, 2019

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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